of four and one-half (4.5) hours per resident day for adults and eight (8) hours per resident day for children, but the provider does not seek approval of staffing beyond those limitations, then the DDARS may investigate whether the provider holds the appropriate type of license.

(d) The per diem rate shall be an all-inclusive rate. The established rate includes all services provided to residents by a facility. The office shall not set a rate for more than one (1) level of care for each community residential facility for the developmentally disabled provider. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-22)*

405 IAC 1-12-23 Medical or nonmedical supplies and equipment; personal care items

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 23. (a) Routine and nonroutine medical supplies and equipment are included in the provider's approved per diem rate, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall the routine and nonroutine medical supplies and equipment be billed through a pharmacy or other provider. Routine supplies and equipment include those items routinely required for the care of residents. Nonroutine medical supplies and equipment are those items for which the need must be demonstrated by the resident's particular condition and identifiable to that resident. The medical records of each resident must indicate, by specific written physician's orders, the order for the service or supply furnished and the dispensing of the service or supply to the resident.

(b) Personal care or comfort items include the following:

(1) Hairbrushes and combs.

(2) Dental adhesives and caps.

(3) Toothpaste.

(4) Shower caps.

(5) Nail files.

(6) Lemon glycerine swabs.

(7) Mouthwashes.

(8) Toothbrushes.

(9) Deodorants.

(10)Shampoos.

(11)Disposable tissues.

(12)Razor.

(13) Any other items or equipment covered by Medicaid and specifically requested by a resident and not routinely provided by the provider.

These items may be included in the approved room charge. Under no circumstances shall items included as personal care or comfort be billed through a pharmacy or other provider to the Medicaid program.

405 IAC 1-12-25 Reimbursement for day services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 25. For CRF/DD facilities, the all-inclusive per diem rate includes reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using

forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate-setting purposes in accordance with this rule.

SECTION 6. **For purposes of implementing amended 405 IAC 1-12, the following shall apply:**

(1) If the effective date of these rule amendments is October 1, 1998, or before, then each provider affected by this rule shall have its Medicaid reimbursement rate set in accordance with these amendments effective with the first rate effective date (RED) as prescribed by sections 5 and 6 of this rule that occurs on or after October 1, 1998. If the effective date of these rule amendments is after October 1, 1998, then each provider affected by this rule shall have its Medicaid reimbursement rate set in accordance with these amendments effective January 1, 1999, with subsequent REDs governed by sections 5 and 6 of this rule.

(2) Beginning on the effective date of this rule and continuing thereafter, the average inflated allowable cost of the median patient day shall be calculated by including each provider's inflated allowable costs of day habilitation services.

(3) These amendments only apply to community residential facilities for the developmentally disabled (CRFs/DD). As such, this SECTION does not apply to nonstate-owned intermediate care facilities for the mentally retarded (ICFs/MR) since costs for active treatment are already included in the all inclusive rate for ICFs/MR.

TO BE CALCULATED USING THE METHODOLOGY DESCRIBED IN TN 92-19.

405 IAC 1-12-26 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 4-21.5; IC 12-13-7-3

Sec. 26. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (c).

(b) If the provider disagrees with a rate redetermination resulting from an audit adjustment or a reportable condition affecting a rate, the provider must request an administrative reconsideration from the Medicaid audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the

Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment or reportable condition. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (c).

(c) After completion of the reconsideration procedure under subsection (a) or (b), the provider may initiate an appeal under IC 4-21.5.

(d) The office may take action to implement Medicaid rates without awaiting the outcome of the administrative process, in accordance with section 1(d) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 1-12-26)*

SECTION 4. (a) The reimbursement rates for all Medicaid-certified nonstate-owned ICF/MR and CRF/DD providers shall be calculated effective on the effective date of this rule. The office or its designee shall promptly calculate new rates under this rule for all Medicaid providers, based on the historical data submitted by providers under the prior rate-setting criteria. Providers with initial interim rates established under the prior rate-setting criteria shall have their rate calculated consistent with the provisions of 405 IAC 1-12-5(a), and made effective on the effective date of this rule. Thereafter, those providers shall be subject to the requirements of 405 IAC 1-12-5(b) and 405 IAC 1-12-4.

(b) The average inflated allowable cost of the median patient day and the fiftieth percentile rate used to calculate rates effective with this rule shall be established on the effective date of this rule. These parameters shall be based on data submitted by providers for rate reviews that are completed as of the effective date of this rule and have a rate effective date prior to the effective date of this rule. Subsequent revisions to these parameters shall be made as prescribed by this rule.

405 IAC 1-12-24 Assessment and rebasing methodology

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15-32-11

Sec. 24. (a) As used in this section, "implementation date" means:

July 1, 1994.

(b) Beginning with the implementation date, CRF/DD and ICF/MR facilities that are not operated by the state will be assessed five percent (5%) of the annual gross residential services revenue of the facility for the facility's preceding fiscal year.

(c) The assessment on provider gross residential services revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Gross residential services revenue is defined as revenue from the provider's previous annual reporting period as set out in section 4(a) of this rule and excludes allowable day costs for the period. Providers will annually submit data to calculate the amount of provider assessment, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(d) If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate-setting purposes.

(d) The provider assessment required by this rule will be considered an allowable cost for cost reporting purposes after the implementation date.

(e) CRF/DD and nonstate-operated ICF/MR facilities certified as Medicaid providers on or before the implementation date will be allowed a one (1) time assessment pass-through adjustment to their per diem rates on the implementation date. This one (1) time assessment pass-through adjustment will be determined as follows:

(1) For providers with annual rate reviews effective on the actual implementation date, the per diem rate will be recalculated by adjusting the inflated allowable per patient day costs plus the allowed profit add-on, and maximum annual limitation (as calculated in section 9(a)(1) of this rule) by five percent (5%) of the prior year Medicaid rate to represent the assessment pass-through.

(2) For providers with annual rate reviews effective on dates other than the implementation date, the per diem rate will be recalculated on the implementation date, with the following modifications:

(A) The inflated allowable per patient day costs plus the allowed profit add-on will be adjusted by five percent (5%) of the prior year Medicaid rate to

represent the assessment pass-through.

(B) The maximum annual limitation will be adjusted as follows:

(i) Five percent (5%) of the prior year Medicaid rate to represent the assessment pass-through.

(ii) The difference between the applicable Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index and the Gross National Product Implicit Price Deflator Index from the latest annual rate review.

For rates that are effective after the effective date of this rule that are based on cost reports that end prior to June 30, 1995, an adjustment to allowable costs will be made by the Office or its representatives to include an annualized amount of the assessment pass-through.

(f) CRF/DD facilities licensed for sheltered living care and nonstate-operated ICF/MR facilities certified as Medicaid providers on or before the implementation date will be allowed a one (1) time rebasing adjustment to their per diem rates on the implementation date. The one (1) time rebasing adjustment will be based on a comparison of applicable rate limitations to the seventieth percentile of rates for CRF/DD facilities licensed for sheltered

living care and nonstate-operated ICF/MR facilities. The seventieth percentile of rates shall be derived from rate reviews for all CRF/DD facilities licensed as sheltered living and nonstate-operated ICF/MR providers that are completed and that have a rate effective date prior to the implementation date. If a provider's current per diem rate on the implementation date is greater than the seventieth percentile rate, no one (1) time rebasing adjustment will be allowed. If a provider's current per diem rate is less than the seventieth percentile rate, the per diem rate will be increased to the lesser of:

(1) the provider's adjusted allowable patient or resident day cost plus the allowed profit add-on; or

(2) the seventieth percentile rate increased five percent (5%) for the assessment pass-through.

(g) CRF/DD facilities licensed for intensive training care and certified as Medicaid providers on or before the implementation date that were previously licensed for sheltered living care on or after October 1, 1991, may request a one (1) time rebasing adjustment to their per diem rates on the implementation date. The one (1) time rebasing adjustment will be based on a comparison of applicable rate limitations to the seventieth percentile per diem rate of CRF/DD facilities licensed for sheltered living care, as determined in subsection (f). If the provider's current per diem rate, reduced by the per resident-day increase in allowable

staffing costs in excess of four and one-half (4.5) hours per resident-day is greater than the seventieth percentile rate, no one (1) time rebasing adjustment will be allowed. If the provider's current per diem rate reduced by the per resident-day increase in allowable staffing costs in excess of four and one-half (4.5) hours per resident day is less than the seventieth percentile rate, the per diem rate in effect at the date of implementation will be increased by the lesser of:

(1) the difference between the seventieth percentile rate, increased five percent (5%), and the recalculated per diem rate, as determined in subsection (e), reduced by the per resident-day increase in allowable staffing costs in excess of four and one-half (4.5) hours; or

(2) the difference between the adjusted inflated allowable patient or resident day cost plus the allowed profit add-on, as determined in subsection (e), reduced by the per resident-day increase in allowable staffing costs in excess of four and one-half (4.5) hours and the recalculated per diem rate, as determined in subsection (e), reduced by the per resident day increase in allowable staffing costs in excess of four and one-half (4.5) hours.

(h) These one (1) time rebasing adjustments will not be performed until all of a provider's existing and prior required